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GASTROENTEROLOGY HISTORY & PHYSICAL

NAME _____

DATE _____ DATE OF BIRTH _____

ADDRESS _____ OCCUPATION _____

_____ INSURANCE _____

PHONE (HOME) _____ PHONE (WORK) _____

SS# _____

FAMILY HISTORY

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐
Panc.	☐	☐	☐	☐	☐	☐
P. U. D.	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐

OTHER _____

_____

MEDICAL HISTORY

☐ Abdominal Pain-Chronic
☐ Anal Pain
☐ Anemia ☐ Bruise Easily
☐ Arthritis/Rheumatism
☐ Asthma/Wheezing
☐ Blood In Urine
Urination- ☐ Overnight >than twice
☐ Painful ☐ Loss of Control
☐ Decrease in Force/Flow
☐ Bronchitis/Chronic Cough
☐ Cancer
☐ Change in Bowel Habits
☐ Chest Pain
☐ Chronic Fatigue
☐ Colitis
☐ Convulsions/Seizures

☐ Crohn's Disease
☐ Diabetes
☐ Diarrhea ☐ Constipation
☐ Difficulty Swallowing
Females- *Please Complete*
Pregnant? ☐ Yes ☐ No
Planning Pregnancy? ☐ Yes ☐ No
Menstrual Flow:
☐ Regular ☐ Irregular ☐ Pain/Cramps
____ Days Flow ____ Length of Cycle
Date _____ 1st day of last period
☐ Diptheria
☐ Diverticulosis
☐ Dizziness/Fainting
☐ Enema use
☐ Fistula

☐ Frequent Infections
☐ Gall Bladder Trouble
☐ Gout
☐ Hemorrhoids
☐ Hepatitis
☐ Hernia
☐ High Blood Pressure
☐ Indigestion or Heartburn
☐ Jaundice/Hepatitis
☐ Kidney Stones
☐ Lactose Intolerance
☐ Loss of Appetite
☐ Mental Illness
☐ Nausea/ Vomiting
☐ Nose Bleeds
☐ Panc.

☐ Peptic Ulcers
☐ Prostate Disease
(
☐ Sexual/Menstrual Dysfunction
☐ Stools
☐ Blood ☐ Mucus
☐ Pus ☐ Incont. ☐ Nocturn
☐ Tenesmus
☐ Stroke
☐ Swollen Ankles
☐ Thyroid Disease
☐ Urethral Discharge
☐ Urine Infections- *Frequent*
☐ Varicose Veins/Phlebitis
☐ Weight Loss- *Recent*

CURRENT SYMPTOMS

☐ Abd. Pain
☐ Anal Pain
☐ Belching
☐ Bloating
☐ Diarrhea ☐ Constipation

☐ Fever
☐ Gas
☐ Gout
☐ Heartburn
☐ Loss of Appetite

☐ Nausea/ Vomiting
☐ Regurg.
☐ Weight Loss
☐ Other _____

☐ Change in Bowel Habits
☐ Stools
☐ Blood ☐ Mucus
☐ Pus ☐ Incont.
☐ Nocturn

DRUG ALLERGIES

MEDICATIONS

HOSPITALIZATION OR SURGERY

Date	Reason	Date	Reason

HABITS

☐ Alcohol: Type _____
Amount _____
☐ Diet: Salt Intake _____
Fat Intake _____
Other _____

☐ Sleep: Difficulty Falling Asleep _____
Continuity Disturbances _____
Early Morning Awakening _____
Daytime Drowsiness _____
Other _____

☐ Smoke: Packs Daily
How Long _____
Interested in Stopping? _____
☐ Exercise Routine: _____

☐ Coffee: Cups Daily _____
Other Caffeine _____
☐ Lift Excessive Weight >25 lbs./day

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